CHUBB

The Trust Sponsored
Professional Liability Insurance Program

THE TRUST

Research or Academic Application: Psychologists' Professional Liability Policy

Insurance Company: ACE American Insurance Company
Administered by: Trust Risk Management Services, Inc.

CLAIMS-MADE/OCCURRENCE DISCLOSURE NOTICE
THE POLICY YOU ARE APPLYING FOR CONTAINS BOTH CLAIMS-MADE AND OCCURRENCE COVERAGES. PLEASE READ THE POLICY IN ITS ENTIRETY. SOME OF THE PROVISIONS CONTAINED IN THE POLICY RESTRICT COVERAGE, SPECIFY WHAT IS AND IS NOT COVERED AND DESIGNATE RIGHTS AND DUTIES.

Applying online at **www.trustinsurance.com** will expedite the approval and delivery of your policy.

You may complete the application below if you do not have Internet access.

A. Please type or print clearly in black ink.

B. Answer ALL questions completely. If any question or part of a question does not apply, print "N/A" in space. LEAVE NO BLANKS.

A

Please complete this section: ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms.

Name: _____

Degree: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Daytime phone number: _____

FAX number: _____

E-mail address: _____

Date of birth: _____ Last four SSN: _____

License Number: _____

Research or Academic Institution: _____

I prefer to have policy and renewal materials sent to me via (select one):

❑ E-mail (fastest) ❑ US Postal Service

I request my insurance coverage become effective on: _____/_____/_____

(This date may not be earlier than the date the application is received by TRMS and not more than 90 days from the date of this application.)

Are you a member of APA? ❑ Yes ❑ No

(Please note that membership is not required to be eligible to apply.)

If Yes, APA member number: _____

Other Association Affinity: _____

* The policy will be sent to you via email, requiring systems that permit you to open and view Adobe Acrobat PDF. You may request a paper copy of your policy at any time. You have the right to withdraw your consent to receive your policy electronically at any time by providing notice to us, however, such withdrawn consent will not affect or change the legal effectiveness, validity or enforceability of any documents that were delivered electronically prior to the date you notified us of the withdrawal of your consent.

B

Select a Limit of Liability:

Standard Protection for Teaching or Research Only

Each Incident	Annual Aggregate	Annual Premium
❑ $1,000,000	$3,000,000	$134
❑ $1,000,000	$1,000,000	$103
❑ $200,000	$600,000	$80
❑ $100,000	$300,000	$70

Expanded Protection for Academicians with Clinical Duties required by the University or Academic Institution

Each Incident	Annual Aggregate	Annual Premium
❑ $1,000,000	$3,000,000	$268
❑ $1,000,000	$1,000,000	$206
❑ $200,000	$600,000	$160
❑ $100,000	$300,000	$140

Please Note: *This application is for a Claims Made policy. The Limit of Liability in effect at the time a Claim is made will be the maximum amount available subject to the terms and conditions of the policy.*

C

Check all the specific types of services provided as a Researcher or Academician:

(If you do not believe that your practice fits into any of the following categories, please attach a brief written description of the services you provide.)

- ❑ Academic Advising
- ❑ Dissertation Committee
- ❑ Serve on University or Department Committees
- ❑ Consultation
- ❑ Research
- ❑ Student Evaluation and Examination
- ❑ Supervision
- ❑ Teaching
- ❑ Clinical Practice (If selected, please indicate the number of clinical hours per week.)

  Number of clinical hours per week required solely as part of your academic responsibilities _____

  Number of clinical hours per week in any other setting _____

- ❑ Other _____ (Please attach a brief written description of the services you provide.)

D

Please answer all of the following:

1. Have you had any Claims or are you aware of any circumstances that may result in a Claim arising out of your professional services *(including incidents or occurrences reported to your prior carrier)?*
   ❑ Yes ❑ No
2. Have you been sanctioned or are you currently under review by any professional ethics body, state licensing board or other regulatory body or ever had your license revoked or suspended?
   ❑ Yes ❑ No
3. Have you been investigated for any HIPAA Privacy Rule violation or Medicare or Medicaid payment violation or are you aware of any such violation that may result in an investigation or proceeding before the United States Department of Health and Human Services (HHS) or its designee, or any state?
   ❑ Yes ❑ No
4. Have you been declined, canceled or nonrenewed by an insurance company for similar insurance? *(MISSOURI APPLICANTS–DO NOT ANSWER.)*
   ❑ Yes ❑ No

   (If you answered "Yes" to questions 1 through 4, please provide more information on a separate sheet of your letterhead and provide ALL available documentation.)

E

Professional Liability Insurance:

1. Have you had Professional Liability Insurance *(excluding student coverage)* in the past 5 years?
   ❑ Yes ❑ No If "No," please skip to section F.

   If "Yes," please list the Named Insured as shown on your current *(or most recent)* insurance policy: _____
2. Was your previous coverage written in the name of your employer?
   ❑ Yes ❑ No If "Yes," please skip to section F.
3. Was this prior policy with the Trust?
   ❑ Yes ❑ No If "No," please provide carrier name: _____
4. Type of Policy: ❑ Claims Made ❑ Occurrence

   If "Claims Made," did you purchase an Extended Reporting Period or Tail?
   ❑ Yes ❑ No If "Yes," please include a copy of your Extended Reporting Period or Tail.
5. Please provide the following information related to your previous policy:

   Effective Date: _____ Expiration Date: _____

   Per Incident Limit: _____ Aggregate Limit: _____

Please submit a copy of your most recent Declarations page. If the policy was Claims Made, this must include your Prior Acts Date or Retroactive Date.

F

Please read, sign and date:

In order to enhance the stability of the Professional Liability Insurance Program, The Trust has formed a purchasing group located and domiciled in Illinois pursuant to legislation enacted by Congress known as the Federal Liability Risk Retention Act of 1986. Coverage will be provided to the purchasing group by ACE American Insurance Company. Once this application has been approved and the premium has been received, you will automatically become a member of the Psychologists Purchasing Group Association and obtain the insurance coverage afforded through the Purchasing Group policy on an annual term, by issuance to you of a copy of the Purchasing Group policy and/or a certificate of insurance. (This paragraph does not apply to New York Applicants.)

I understand that I am not covered by this insurance if I am any of the following: physician, surgeon, dentist, surgeon's/physician's assistant, perfusionist, electroneurodiagnostic technologist, or cytotechnologist. I understand that these professional occupations are excluded from coverage. I understand I am not covered as a proprietor, owner, partner, manager, superintendent or officer of any hospital, sanitarium, medical clinic, health maintenance organization, managed care facility or network. I understand that this insurance will not apply for any owners who have proprietor or financial interest in any residential/overnight facility except in the delivery of professional services. The insurance described herein is subject to all terms, conditions and exclusions of the policy.

This application is subject to the underwriter's approval. Your completion of this application and premium payment does not obligate the insurance company to issue you insurance coverage. Coverage will become effective following approval of your application and clearance of your premium.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

The applicant declares the information contained in the application and any attachments hereto is true and complete and that no material facts have been concealed, suppressed, misrepresented or misstated. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines, or confinement in prison, or any combination thereof.

NOTICE TO ARKANSAS, LOUISIANA, WEST VIRGINIA, & RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO CALIFORNIA APPLICANTS: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subjected to fines and confinement in state prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: Any person who knowingly and with intent to defraud any Insurance company or Another person, files an application for insurance containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and MAY subject such person to criminal and civil penalties.

NOTICE TO MISSOURI APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: WARNING: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO ALL OTHER APPLICANTS: Any person who knowingly and with intent to defraud any Insurance company or Another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and MAY subject such person to criminal and civil penalties. I understand that the insurance applied for provides coverage for covered claims as a result of acts that occur while the policy is in force. The undersigned acknowledges and agrees that information contained in this application, as well as subsequent information released in the underwriting or claim settlement process may be shared with the Trust for the purpose of their advocating on your behalf or development of risk management materials. For purposes of risk management materials, individual confidentiality will be protected.

Completion of this form does not bind coverage. The applicant's acceptance of the company's quotation is required before the applicant may be bound and a policy issued. The applicant agrees if the insurance coverage applied for is written, that this application and any attachments are deemed physically attached thereto and incorporated into the policy.

SIGNATURE OF APPLICANT X_____ DATE X _____

(This must be signed by the individual applying for insurance. Signature stamps are not acceptable.)

Please return your completed application to:

Trust Risk Management Services, Inc.
1791 Paysphere Circle
Chicago, IL 60674

For faster service apply online at www.trustinsurance.com. If replacing coverage, please return your application at least 30 days before your expiration date. Please type or print clearly. Answer ALL questions completely.

Underwritten by ACE American Insurance Company. Administered by Trust Risk Management Services, Inc. (Florida Producer Sheila LeBeau License #PO99941). The completion of this application or the tendering of premium does not bind coverage. The application is subject to the Company's Underwriting Rules.

If you have any questions, please call TRMS toll-free at 1-877-637-9700 or E-mail TRMS at info@trustrms.com. Fax 1-877-251-5111.

If you prefer to pay by credit card, we accept Visa, Mastercard, Discover and American Express. Please provide credit card information in the space below if payment by credit card is desired.

❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Name on Card: _____

Signature: _____

Card Number: _____

Exp Date (MM/YY): _____ Amount: _____

Credit Card Billing Address: ❑ Same as Address in Section A

_____

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